STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155389	A. BUILDING 00 B. WING	06/03/2014

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
WESTPARK HEALTHCARE CENTER	1316 N TIBBS AVE INDIANAPOLIS, IN 46222

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
F000000	This visit was for a Recertification and State Licensure survey. This visit included investigation of complaint # IN00149201. Complaint #IN00149201- Substantiated. Federal/State deficiencies related to the allegations are cited at F157, F166, F280. Survey date(s): May 28, 29, 30, June 2 and 3, 2014 Facility number: 000473 Provider number: 155389 AIM number: 100290410 Survey Team: Lora Brettnacher, RN - TC Megan Burgess, RN Kewanna Gordon, RN Laura Brashear, RN (5/28, 5/29, 6/02, 6/03, 2014) Mary Weyls, RN (5/28, 5/29, 6/02, 6/03, 2014) Census Bed Type: SNF/NF: 58 Total: 58 Census Payor Type: Medicare: 17 Medicaid: 39	F000000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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	Other: 2 Total: 58 These deficiencies reflect state findings cited in accordance with 410 IAC 16.2-3.1. Quality review completed on 06/10/2014 by Brenda Marshall, RN.			
F000157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form			

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	of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's legal representative or interested family member.			
	Based on record review and interview, the facility failed to notify family when a resident had a change in condition for 1 of 3 residents reviewed for family notification of change (Resident B). Findings include: Resident B's record was reviewed on 5/30/14 at 9:30 A.M. Resident B had diagnoses which included, but were not limited to, dementia, contractures, benign prostate hyperplasia with urinary obstruction, and hypertension. An admission minimum data set assessment tool (MDS) dated 4/28/2014, indicated Resident B had severe cognitive impairment and had family involved in his care.	F000157	Preparation and/or execution of this plan of correction in general, or this corrective action in particular, does not constitute an admission of agreement by this facility of the facts alleged or conclusions set forth in this statement of deficiencies. The plan of correction and specific corrective actions are prepared and/or executed in compliance with State and Federal Laws. The facility is requesting paper compliance for all deficiencies in this POC. The facility's intent is to notify the family when a resident has a change of condition. A: ACTIONS TAKEN: 1. Resident B is no longer in the facility. B: OTHERS IDENTIFIED: 1. 100% audit completed at the time of occurrence. No others affected. C: MEASURES TAKEN: 1. An in-service was completed with	06/23/2014

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	A physician's order dated 4/25/14 at 3:15 P.M., indicated Resident B had developed an open area on his penis and the physician ordered a treatment for the open area. The record lacked documentation Resident B's family had been notified of the open area or the treatment ordered by the physician. During an interview on 5/29/14 at 11:00 A.M., Resident B's family indicated they were not informed of the open area on his penis or the treatment the physician ordered. During an interview on 5/30/14 at 11:45 P.M., Unit Manager Licensed Practical Nurse (LPN) #2, indicated documentation was not available which indicated Resident B's family had been notified about the open area on his penis. A policy titled "Notification of Changes" dated 2/00, and identified as a current policy by the Director of Nursing (DON) on 6/2/2014 at 9:47 A.M., indicated, "...Purpose: To keep the Resident, legal representative (or interested family member), and physician (when applicable) aware of changes which directly affect the care and welfare of the Resident.... This facility shall immediately inform...an interested family member		nursing staff on the policy and procedure for notifying a resident's family/responsible party of any changes in condition and documentation of the notification. D: HOW MONITORED: 1. The DON/Designee will monitor all orders in the daily clinical meeting. 2. DON/Designee will review family notification daily for a week, weekly for 2 weeks, and monthly for 3 months; Then the results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring needs. 3. The Administrator will review all audits weekly. Any inconsistent results will be immediately clarified and corrected appropriately. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 6/23/14.	

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	when there is...a need to...commence a new form of treatment...All notifications shall be...recorded in the Resident's medical record...." This Federal tag relates to Complaint #IN00149201. 3.1-5(a)(3)			
F000166 SS=D	483.10(f)(2) RIGHT TO PROMPT EFFORTS TO RESOLVE GRIEVANCES A resident has the right to prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents. Based on record review and interview, the facility failed to ensure residents' grievances were resolved and/or were appropriately apprised of the facilities progress toward the resolution. This deficient practice affected 1 of 3 residents reviewed for grievances (Resident B). Findings include: During an interview on 5/29/14 at 11:00 A.M., Resident B's family indicated on	F000166	The facility's intent is to ensure resident's grievances were resolved and/or were appropriately apprised of the facility's progress toward the resolution. A: ACTIONS TAKEN: 1. Resident B grievances were addressed and completed B: OTHERS IDENTIFIED: 1. 100% audit completed at the time of occurrence. No others affected. C: MEASURES TAKEN: 1. An in-service was completed with staff regarding the facility's policy and procedure for grievances. D:	06/23/2014

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	5/9/2014, they reported to the facility Resident B had missing clothes. Resident B's family indicated the facility had not contacted them regarding their concern. During an interview on 5/30/14 at 1:37 P.M., the House Keeping Supervisor indicated on 5/9/14, Resident B's family arrived to take him home. At this time his son informed her of missing clothing. She indicated she had not found all of the clothing and had not documented the missing items in the grievance log. During an interview on 5/30/2014 1:52 P.M., the Director of Nursing (DON) indicated a grievance form should have been filled out but it had not been done. Resident B's record was reviewed on 5/30/14 at 9:30 A.M. Resident B had diagnoses which included, but were not limited to, dementia, contractures, benign prostate hyperplasia with urinary obstruction, and hypertension. An admission minimum data set assessment tool (MDS) dated 4/28/2014, indicated Resident B had severe cognitive impairment. An undated policy titled "Grievance/Complaint Form" identified		HOW MONITORED: 1. Grievances will be reviewed, discussed, and monitored as per policy in the daily management morning meeting. Social Services will verify daily that all grievances are being followed as per the policy and procedure. 2. The Administrator will review all grievance logs weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring needs. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 6/23/14.	

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	as a current policy by the Director of Nursing (DON) on 6/2/2014 at 9:17 A.M., indicated, "Policy: The resident or significant other has the right to voice grievances without discrimination or reprisal for voicing the grievance. Efforts will be made by the facility staff to resolve the grievance within three working days. The concerned party will be notified of the resolution. Procedure: 1. Complaint/Grievances should be directed to the Department Head...2. The employee receiving the grievance/complaint will complete #1-8 of the Grievance/Complaint form. 3.. The person receiving the grievance/complaint should make every effort to resolve the grievance and record the action taken #9. If it can not be resolved by the person receiving the complaint, the Assistant Administrator must be informed. 4. When the grievance/complaint is resolved, immediately complete #10. 5. Give the form to the Assistant Administrator who will bring the report to the Department Head meeting for any possible discussion. 6. The report will be signed by the Assistant Administrator and or the Administrator. 7. The complaint is to be logged onto the Complaint/Grievance Log This Federal tag relates to Complaint			

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	#IN00149201. 3.1-7(a)(2)			
F000242 SS=E	483.15(b) SELF-DETERMINATION - RIGHT TO MAKE CHOICES The resident has the right to choose activities, schedules, and health care consistent with his or her interests, assessments, and plans of care; interact with members of the community both inside and outside the facility; and make choices about aspects of his or her life in the facility that are significant to the resident. Based on interview and record review, the facility failed to ensure residents were assessed for and given a choice regarding their preferences of frequency of bathing/showers for 3 of 3 residents reviewed who met the criteria for choices (Residents #53, #118, and #75). Findings include: 1. Resident #53 was interviewed on 5/28/14 at 12:36 p.m. When the resident was asked if he had been asked as to how many showers he would prefer to have weekly the resident indicated he had not been asked and received two. Resident #53's record was reviewed on	F000242	The facility's intent is to ensure residents are assessed for and given a choice regarding their preferences of frequency of bathing/showers. A: ACTION TAKEN: 1. Residents #53, #118, and #75 preferences were confirmed by interview for frequency/choices related to bathing/ showering. B: OTHERS IDENTIFIED: 1. All other residents have the potential to be affected. All residents have been interviewed as appropriate for their preferences and individual plans of care updated accordingly. Residents were notified of the procedure for preferences, to include changes as needed and quarterly care plan meetings. C: MEASURES TAKEN: 1. An in-service was completed with the IDT team in	06/23/2014

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	5/28/14 at 1:30 P.M. A Minimum Data Set (MDS) assessment, dated 2/12/14, indicated Resident #53 had moderate cognitive impairment. 2. During a family interview on 5/29/14 at 1:14 p.m., Resident # 118's sister indicated he did not have a choice regarding the number of showers he was able to take per week. When asked about the resident shower schedule she stated, "Twice a week according to the wards, they have never asked me, it is a part of their curriculum." Resident #118's record was reviewed on 5/29/14 at 10:50 A.M. Resident #118 had a diagnose which included, but was not limited to, dementia. 3. During an interview on 5/29/14 at 10:05 A.M., Resident #75 indicated the facility did not ask his preference regarding frequency of bathing. He indicated he was given two showers a week but if he was at home he would take one every day. Resident #75's record was reviewed on 6/2/14 at 10:41 A.M. Resident #75 had diagnoses which included, but were not limited to, post right above elbow amputation, diabetes, hypertension, and osteomylitis. An admission minimum data set		relation to a new form for preferences for showering/bathing that is to be completed upon admission. D: HOW MONITORED: 1. Admission records will be brought to daily morning meeting and reviewed for completion of the preference form. During quarterly care plan meetings, Social Services will ask the resident/family if any changes to the preferences are needed. 2. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring needs. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 6/23/14.	

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	assessment tool (MDS) dated 1/6/14, indicated Resident #75 was cognitively intact with a brief mental status score (BIMS) of 13 out of 15 and it was very important for him to "choose between a bed bath, shower, or tub bath." During an interview on 5/30/14 at 1:39 P.M., Licensed Practical Nurse (LPN) #2 indicated shower schedules were assigned to residents by their room numbers. During an interview on 6/2/14 at 11:33 A.M., the Director of Nursing (DON) indicated because the MDS did not ask for residents' preferences regarding the frequency of showers/bathing, the facility had not sought out their preferences. She indicated current facility practice was to initially assign residents two showers a week and if they informed staff they were not satisfied they would change it. An undated policy titled "Resident Rights" identified as current by the DON on 6/3/14 at 12:00 P.M., indicated, "...Free Choice-The resident has the right to...participate in planning care...." 3.1-3(u)(1)			
F000279 SS=D	483.20(d), 483.20(k)(1) DEVELOP COMPREHENSIVE CARE			

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	PLANS A facility must use the results of the assessment to develop, review and revise the resident's comprehensive plan of care. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and mental and psychosocial needs that are identified in the comprehensive assessment. The care plan must describe the services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being as required under §483.25; and any services that would otherwise be required under §483.25 but are not provided due to the resident's exercise of rights under §483.10, including the right to refuse treatment under §483.10(b)(4).			
	Based on record review and interview, the facility failed develop comprehensive care plans for 2 of 26 residents reviewed for care plans (Resident B and Resident #125). Findings include: Resident B's record was reviewed on 5/30/14 at 9:30 A.M. Resident B had diagnoses which included, but were not limited to, dementia, contractures, benign prostate hyperplasia with urinary obstruction, and hypertension. An admission assessment note dated	F000279	The facility's intent is to develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. A: ACTIONS TAKEN: 1. Resident B is no longer a resident. Resident # 125's comprehensive care plans are completed. B: OTHERS IDENTIFIED: 1. 100% audit completed at the time of occurrence. No others affected. C: MEASURES TAKEN: 1. An in-service was completed with staff regarding the facility's policy and procedure for comprehensive	06/23/2014

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	4/21/2014, indicated Resident B had swollen genitals and a swollen penis. The record lacked documentation a care plan had been developed to address his swollen genitals and/or penis. A physician's order dated 4/25/14 at 3:15 P.M., indicated Resident B had developed an open area on his penis and the physician ordered a treatment to be applied every shift. The record lacked documentation of a care plan to address the open area on his penis. During an interview on 5/30/14 at 1:23 P.M., LPN (Licensed Practical Nurse) #5 indicated she had completed Resident B's admission assessment. She indicated when he was admitted his penis and scrotum were both swollen. During an interview on 5/30/14 at 1:28 P.M., LPN #6 indicated it was her responsibility to develop care plans. She indicated she had not developed a care plan regarding Resident B's swollen scrotum, his swollen penis, or the open area on his penis. 2. A review of Resident # 125's chart, on 6/2/14 at 1:30 p.m., indicated the resident was admitted on the psychotropic medication quetiapine, the antidepressant duloxetine, and the anti-anxiety medication Lorazepam. The record		care plans. 2. The interim plan of care is initiated upon admission and a comprehensive care plan is developed within 7 days after completion of the comprehensive assessment. D: HOW MONITORED: 1. New admission records will be reviewed daily in the morning meeting for plan of care. Within 14 days of admission a comprehensive plan of care will be developed. The MDS Coordinator will audit records weekly for completion of the comprehensive care plans. 2. The Administrator will review all audits weekly. Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring needs. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 6/23/14.	

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	lacked documentation of care plans for anti-psychotic, anti-depressant, or anti-anxiety medications. During an interview on 5/30/14 at 1:28 P.M., LPN #6 indicated it was her responsibility to develop care plans. She indicated she had not developed a care plan Resident #125's anti-psychotic, anti-depressant, or anti-anxiety medications. An undated policy identified as current by the DON on 6/2/2014 at 9:17 A.M., indicated, "...Comprehensive Care Plan-The plan of care is initiated upon admission and a comprehensive care plan is developed within seven (7) days after completion of the comprehensive assessment. The care plan is based on strengths and needs identified by the assessment. The plan is developed by an interdisciplinary team which identifies strengths, problems and needs; establishes measurable objectives with timetables to meet the objectives; and determines approaches necessary to accomplish the objectives...." 3.1-35(a)			
F000280 SS=D	483.20(d)(3), 483.10(k)(2) RIGHT TO PARTICIPATE PLANNING CARE-REVISE CP			

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	The resident has the right, unless adjudged incompetent or otherwise found to be incapacitated under the laws of the State, to participate in planning care and treatment or changes in care and treatment. A comprehensive care plan must be developed within 7 days after the completion of the comprehensive assessment; prepared by an interdisciplinary team, that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs, and, to the extent practicable, the participation of the resident, the resident's family or the resident's legal representative; and periodically reviewed and revised by a team of qualified persons after each assessment. Based on record review and interview, the facility failed to ensure families were included in the development of a resident's comprehensive care plan for 1 of 3 resident family's interviewed for participation with care planning (Resident B). Findings include: Resident B's record was reviewed on 5/30/14 at 9:30 A.M. Resident B had diagnoses which included, but were not limited to, dementia, contractures, benign prostate hyperplasia with urinary obstruction, and hypertension. During an interview on 5/29/14 at 11:00 A.M., Resident B's family indicated the	F000280	The facility's intent is to ensure families are included in the development of a resident's comprehensive care plan. A: ACTIONS TAKEN: 1. Resident B is no longer in the facility. B: OTHERS IDENTIFIED: 1. 100% audit completed at the time of the occurrence. No others affected. C: MEASURES TAKEN: 1. An in-service was completed with staff regarding the facility's policy and procedure for care plan meetings. D: HOW MONITORED: 1. The MDS Coordinator will review the scheduled care plan meetings weekly in the morning meeting. The MDS Coordinator will send the resident/responsible party an invitation to the care plan meetings, which are held weekly at the facility and as needed. 2.	06/23/2014

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	155389	A. BUILDING 00 B. WING	06/03/2014

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	facility did not have a care plan meeting to inform them of Resident B's care and treatment plan. During an interview on 5/30/14 at 1:28 P.M., LPN (Licensed Practical Nurse) #6 indicated she did not have a care plan meeting with Resident B's family. She indicated she did not have an explanation as to why it wasn't done. An undated policy identified as current by the DON (Director of Nursing) on 6/2/2014 at 9:17 A.M., indicated, "...Comprehensive Care Plan-The plan of care is initiated upon admission and a comprehensive care plan is developed within seven (7) days after completion of the comprehensive assessment. The care plan is based on strengths and needs identified by the assessment. The plan is developed by an interdisciplinary team which identifies strengths, problems and needs; establishes measurable objectives with timetables to meet the objectives; and determines approaches necessary to accomplish the objectives... To assure continued accuracy, the comprehensive care plan is reviewed, evaluated, and undated as needed, but a least quarterly, by the interdisciplinary team with participation from the resident, resident's family member, or legal representative...."		Any inconsistent results will be immediately clarified and corrected appropriately. Results will be monitored and reviewed at the monthly and quarterly QA Meetings for determination of ongoing monitoring needs. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 6/23/14.	

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	This Federal tag relates to Complaint #IN00149201 3.1-35(c)(2)(C)			
F000282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. Based on observation, interview, and record review, the facility failed to ensure a resident's plan of care, as well as facility policy and procedure, were implemented in regard to checking for residual of a gastrostomy tube prior to flushing with water or administering medications for 1 of 1 residents observed during medication administration with gastrostomy tubes [g-tube] (Resident #39). Findings include: The record for Resident #39 was reviewed on 6/3/2014 at 10:00 a.m. Resident #39 had diagnoses which included, but were not limited to, anemia, hypercholesterolemia, stroke, hypertension, diabetes mellitus,	F000282	The facility's intent is to ensure a resident's plan of care, as well as facility policy and procedure, were implemented in regard to checking for residual of a gastrostomy tube prior to flushing with water or administering medications. A: ACTIONS TAKEN: 1. Resident # 39 had no negative effects from medication observation. B: OTHERS IDENTIFIED: 1. No other resident with G-Tubes in facility. C: MEASURES TAKEN 1. A 1:1 in-service was completed with LPN #3. 2. An in-service was completed with nursing staff regarding the facility's policy and procedure for checking residual prior to administering medications via g-tube. D: HOW MONITORED: 1. DON/Designee will observe 3 g-tube medication passes every week for 2 weeks, 1 g-tube medication pass weekly	06/23/2014

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	depression, dysphagia, aphasia, left sided hemiparesis, bradycardia, and constipation. A plan of care dated 1/17/2013, indicated Resident #39 had a high risk for aspiration. Interventions to prevent aspiration included nursing staff would check for residual prior to water flushes and prior to the administration of medication through the g-tube. During an observation of medication administration on 5/30/2014 at 10:25 a.m., LPN (Licensed Practical Nurse) #3 checked for g-tube placement via the air bolus method. She then administered medications into Resident #39's G-tube. LPN #3 checked a second time for g-tube placement via the air bolus method. She then flushed the g-tube with water. LPN #3 was not observed to check for residual. During an interview on 6/3/2014 at 10:45 a.m., the DoN (Director of Nursing) indicated LPN #3 should have checked for residual LPN #3 should have aspirated the exterior opening of Resident #39's gastrostomy tube with the syringe prior to administering medications. A policy titled "Enteral Tube Medication Administration Procedure" dated		for a month, and monthly for 3 months. Following that, the results will be monitored and reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring needs. 2. Any inconsistent results will be immediately clarified and corrected appropriately. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 6/23/14.	

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	2/6/2014 and identified as current by the DoN on 5/30/2014 at 2:13 p.m. indicated the following: "Enteral Tube Medication Administration Procedure... Purpose: To safely and accurately administer oral medications through an enteral tube... Procedure: ...Check for tube placement and patency and residual..." 3.1-35(g)(2)			
F000431 SS=E	483.60(b), (d), (e) DRUG RECORDS, LABEL/STORE DRUGS & BIOLOGICALS The facility must employ or obtain the services of a licensed pharmacist who establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation; and determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled. Drugs and biologicals used in the facility must be labeled in accordance with currently accepted professional principles, and include the appropriate accessory and cautionary instructions, and the expiration date when applicable. In accordance with State and Federal laws, the facility must store all drugs and			

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	biologicals in locked compartments under proper temperature controls, and permit only authorized personnel to have access to the keys. The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected. Based on observation, interview, and record review the facility failed to dispose of expired medications. The failure to discard these medications had the potential to affect 5 of the 8 residents whose medications were observed being stored on the medicine cart for the middle hall (Residents #2, #34, #40, #44, and #57). Findings include: During an observation on 6/3/14 at 10:15 a.m., of the middle hall medicine cart with LPN #4, eight containers of opened expired medications were found including; 1."Refresh Tears," (ophthalmic)with an opened date of, 11/5/13, for use by Resident #2 2. "Artificial Tears," (ophthalmic)with	F000431	The facility's intent is to ensure timely disposal of expired medications. A: ACTIONS TAKEN: 1. The middle hall medication cart was audited and all expired medications were removed and destroyed. B: OTHERS IDENTIFIED: 1. 100% audit of all medication carts was completed at the time of the occurrence. No others affected. C: MEASURES TAKEN: 1. An in-service was completed with nursing staff regarding expiration dates of medication as well as removal of expired medications from the cart. D: HOW MONITORED: 1. The night nurse will audit the medication carts weekly for expired medications. 2. The DON/Designee will monitor/audit each medication cart 3X/ weekly for 1 week, weekly for a month, and monthly for 3 months for compliance. Then, results will be monitored and	06/23/2014

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	the notation, "5/16 do not use after this date", for use by Resident # 57. 3. "Natural Balance Tears," (ophthalmic)with an opened date of, 12/21/13, for use by Resident # 40. 4. "Artificial Tears Ointment," (ophthalmic)with an opened date of, 1-2-14, for use by Resident #40. 5. "Natural Balance Tears," (ophthalmic)with an opened date of, 9/30/13, for use by Resident # 44. 6. "Nitrostat," (nitroglycerin tabs)with an opened date of, 9/20/13, for use by Resident # 40. 7. "Nitrostat," (nitroglycerin tabs)with an opened date of, 2/5/13, for use by Resident # 34. 8. "Nitrostat," (nitroglycerin tabs)with an opened date of, 11/10/13, for use by Resident # 2. During an interview on 6/3/14 at 10:15 a.m., LPN # 4 indicated she thought the medications were able to be used through the manufacturers listed expiration date. A review of a document entitled, "Expiration dates of Perishable Medications," received on 6/3/14 at 10:20 a.m., from Unit Manager #2, indicated, the expiration date for ophthalmic preparations was 90 days after opening. The document further indicated that the expiration date for		reviewed at the monthly and quarterly QA Meeting for determination of ongoing monitoring needs. 3. Any inconsistent results will be immediately clarified and corrected appropriately. E: This plan of correction constitutes our credible allegation of compliance with all regulatory requirements. Our date of completion is 6/23/14.	

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	nitroglycerin tablets was 6 months after opening. 3.1-25(o)			